Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA RIO GRANDE REGIONAL
HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

TRAVELERS INDEMNITY CO OF CONN

Carrier's Austin Representative Box

Box Number 39

MFDR Tracking Number

M4-99-2176-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The provider submitted the billing for the same and received a payment from Travelers, the carrier, in the amount of $3,498.00." "First the per diem rates contained in the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas…As a result the holding of the Supreme Court, the carrier is obligated to pay the full charges, and is stopped from asserting void rates are fair and reasonable." "In light of the above, the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

Amount in Dispute: $4263.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

I. "Deficiency of Request.
II. Carrier's Supporting Documents.
III. Carrier's Justification for Payment Amount.
IV. **Conclusion**. The requester has failed to meet its burden to show that the reimbursement received was insufficient under the requirements of the Texas Labor Code."

Response Submitted by: Travelers Indemnity Co. of Conn, FOL, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 11, 1997 through August 14, 1997	Inpatient Hospital Services	$4263.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on August 7, 1998.
4. Neither party to this dispute submitted copies of explanation of benefits to support the respondent's reduction of payment for the disputed services.

Findings

1. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
2. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three (3) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
3. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
4. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 3 days multiplied by $1,118.00 = $3,354.00.

   A review of the submitted TWCC-60 supports reimbursement of $3498.00 for inpatient surgical services; therefore, the requestor was paid in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).
5. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of explanation of benefits or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).

   The request for additional reimbursement is not supported.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305(d). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/15/2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.